

Pediatricians can provide support, education when child has cleft lip/palate

February 29, 2016

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Article type: [Focus on Subspecialties](#)

Topics: [Birth Defects](#)

Cleft lip and/or cleft palate (CL/P) are among the most common birth defects. Care of patients with CL/P spans pre- or postnatal diagnosis into adulthood.

While timing and sequence of specific cleft-related care is essential to optimizing outcomes, care should be individualized to meet the needs of each patient.

Children with CL/P should receive their specialty cleft-related care from a multidisciplinary cleft or craniofacial team with sufficient patient and surgical volume to promote successful outcomes.



Cleft lip and/or cleft palate (CL/P) are among the most common birth defects. The primary care pediatrician at the child's medical home has an essential role in making timely diagnosis and referral; providing ongoing health care maintenance, anticipatory guidance and acute care; and functioning as an advocate and a liaison between the family and the craniofacial/cleft team.

Many cleft lips are identified prenatally. Shock, grief, guilt and worry are common parental reactions upon learning the baby they are expecting will have a birth defect. Parents will look to their pediatrician for support, guidance and information about CL/P. Additionally, many cleft and craniofacial teams provide prenatal counseling and education to help families prepare for the birth of their child.

In contrast, a cleft palate typically is diagnosed after a baby is born. Though a cleft palate usually is not seen on prenatal ultrasound and is not immediately visible after a baby is born, the implications of the cleft palate for the infant's health and well-being are soon apparent. The presence of a cleft palate prevents a baby from sucking normally either from the breast or bottle. A variety of cleft feeders are available for infants born with a cleft palate with or without cleft lip.

In addition, children with cleft palates are more likely than other children to have Eustachian tube dysfunction, middle ear effusion, cleft-specific speech problems, and to need orthodontic treatment and orthognathic surgery. Children with only cleft palate also have a higher risk of an underlying syndrome compared to children with cleft lip with or without cleft palate.

Orofacial cleft care and management extend from infancy through adolescence and, in some cases, into adulthood. However, initial reconstructive surgeries typically occur within the first year of life. A cleft lip usually is repaired between 3 and 6 months of age, and a cleft palate is repaired between 9 and 14 months. If there is a cleft gum line, it usually is repaired when a child is 8-10 years of age.

Children with CL/P often need other surgeries, including speech surgery, rhinoplasty and jaw surgery.

While surgeries are important milestones, children with CL/P need close and ongoing attention to oral health, speech, hearing, growth and development. Good oral health and access to regular professional dental and orthodontic care are essential components of care for children with CL/P.

To aid pediatricians, the AAP Section on Oral Health is preparing a clinical report titled *The Primary Care Pediatrician and the Care of Children with Cleft Lip and/or Cleft Palate*.

Dr. Lewis is a member of the AAP Section on Oral Health.

Resource

- ["Parameters for Evaluation and Treatment of Patients with Cleft Lip/Palate and Other Craniofacial Anomalies" from the American Cleft Palate-Craniofacial Association \(2009\)](#)

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